FOR OHF USE

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045153

Facility Name: SYCAMORE HEALTHCARE CENTRE

Address: 720 SYCAMORE (Number) QUINCY (City) 62301 (Zip Code)

County: ADAMS

Telephone Number: (847) 674-5795 **Fax #** (847) 674-5794

IDPA ID Number: 36-4397994

Date of Initial License for Current Owners: 10/18/00

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MORRIS ESFORMES
(Title) MEMBER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	94	Skilled (SNF)	94	34,404	1
2		Skilled Pediatric (SNF/PED)			2
3	111	Intermediate (ICF)	111	40,626	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	205	TOTALS	205	75,030	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,788	750	5,032	11,570	8
9	SNF/PED					9
10	ICF	33,237	4,938		38,175	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,025	5,688	5,032	49,745	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.30%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/18/00

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/18/00 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 94 and days of care provided 5,032

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	195,126	15,680	8,803	219,609		219,609		219,609			1
2	Food Purchase		189,245		189,245	(1,373)	187,872	(1,194)	186,678			2
3	Housekeeping	125,967	20,113		146,080		146,080		146,080			3
4	Laundry	96,827	13,793	924	111,544		111,544	138	111,682			4
5	Heat and Other Utilities			134,915	134,915		134,915	256	135,171			5
6	Maintenance	82,497	16,120	31,414	130,031		130,031	4,996	135,027			6
7	Other (specify):*			22,926	22,926		22,926	51	22,977			7
8	**TOTAL General Services**	500,417	254,951	198,982	954,350	(1,373)	952,977	4,247	957,224			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,482,571	77,897	17,705	1,578,173		1,578,173		1,578,173			10
10a	Therapy	149,180		2,195	151,375		151,375		151,375			10a
11	Activities	70,558	5,840		76,398		76,398		76,398			11
12	Social Services			8,099	8,099		8,099		8,099			12
13	Nurse Aide Training											13
14	Program Transportation			162	162		162		162			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,702,309	83,737	40,161	1,826,207		1,826,207		1,826,207			16
	C. General Administration											
17	Administrative	70,000		40,000	110,000		110,000	15,786	125,786			17
18	Directors Fees											18
19	Professional Services			35,513	35,513		35,513	6,844	42,357			19
20	Dues, Fees, Subscriptions & Promotions			39,164	39,164		39,164	(22,158)	17,006			20
21	Clerical & General Office Expenses	60,481	20,831	14,828	96,140		96,140	25,454	121,594			21
22	Employee Benefits & Payroll Taxes			384,072	384,072	1,373	385,445		385,445			22
23	Inservice Training & Education			4,943	4,943		4,943	56	4,999			23
24	Travel and Seminar			2,707	2,707		2,707		2,707			24
25	Other Admin. Staff Transportation			11,254	11,254		11,254	558	11,812			25
26	Insurance-Prop.Liab.Malpractice			92,856	92,856		92,856	389	93,245			26
27	Other (specify):*			119,387	119,387		119,387	(115,095)	4,292			27
28	**TOTAL General Administration**	130,481	20,831	744,724	896,036	1,373	897,409	(88,166)	809,243			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,333,207	359,519	983,867	3,676,593		3,676,593	(83,919)	3,592,674			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: SYCAMORE HEALTHCARE CENTRE #0045153 **Report Period Beginning: 01/01/2004** **Ending: 12/31/2004**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	8,803	
	REPAIRS & MAINTENANCE		0	
			0	8,803
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		924	
			0	924
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		32,834	
	ELECTRICITY		68,235	
	WATER		21,492	
	CABLE TV - LOBBY		12,354	
			0	134,915
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		629	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		2,815	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		19,659	
	ELEVATOR MAINTENANCE & REPAIR		5,184	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,042	
	FIRE SERVICE		1,085	
			0	
			0	
			0	31,414
7	**OTHER**			
	SCAVENGER		13,926	
	SECURITY SERVICE		9,000	22,926
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	12,000	12,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	0	
	LABORATORY & XRAY EXPENSE		2,421	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	2,250	
	PHARMACY CONSULTANT	XVIII B 39-2	3,284	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	9,750	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	17,705
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	1,861	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	247	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	87	2,195
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	8,099	
	SOCIAL WORKER	XVIII B 45-2		
			0	8,099
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE **#0045153** **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		162	162
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	40,000	40,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	13,443	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	22,070	
			0	35,513
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	17,265	
	EMPLOYEE WANT ADS	XIX F	5,902	
	CONTRIBUTIONS	VI 20 XIX F	780	
	DUES & SUBSCRIPTIONS	XIX F	6,464	
	LICENSES & PERMITS	XIX F	3,859	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	1,157	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	150	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	3,587	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	39,164
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		10	
	EQUIPMENT REPAIR & MAINTENANCE		3,533	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		11,285	
	MESSENGER SERVICE		0	
			0	14,828

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	174,384	
	UNEMPLOYMENT COMPENSATION	XIX D	55,544	
	WORKERS COMPENSATION INSURANCI	XIX D	82,099	
	HOSPITALIZATION INSURANCE	XIX D	57,386	
	EMPLOYEE BENEFITS - OTHER	XIX D	14,659	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	384,072
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		4,943	4,943
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	2,707	
			0	
			0	2,707
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		11,254	11,254
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		92,856	92,856
27	**OTHER**			
	BAD DEBTS	VI 24	119,387	
				119,387

GRAND TOTAL COLUMN 3 OTHER 983,867

SYCAMORE HEALTHCARE CENTRE
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2004

TOTAL FOOD PURCHASE	189,245	PATIENT MEALS	149235
LESS SALES TAX	(1,194)	ADD EMPLOYEE MEALS	1098
NET FOOD	188,051	TOTAL MEALS/YEAR	150333
TOTAL PATIENT CENSUS	49,745	NET FOOD	188051
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	150333
TOTAL PATIENT MEALS	149235	COST PER MEAL	1.25
		TIME EMPLOYEE MEALS	1098
ADD # EMPLOYEE MEALS/DAY	3		
TIME # DAYS	366	EMPLOYEE MEAL RECLASSIFICATION	1373
TOTAL EMPLOYEE MEALS	1098		

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE #0045153 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			43,549	43,549		43,549	128,613	172,162			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			48,415	48,415		48,415	288,647	337,062			32
33	Real Estate Taxes			34,940	34,940		34,940	1,098	36,038			33
34	Rent-Facility & Grounds			477,106	477,106		477,106	(477,106)				34
35	Rent-Equipment & Vehicles			24,411	24,411		24,411	3,974	28,385			35
36	Other (specify):* **RENT - IME**			8,034	8,034		8,034	(8,034)				36
37	**TOTAL Ownership**			636,455	636,455		636,455	(62,808)	573,647			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		101,075	280,553	381,628		381,628		381,628			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			112,546	112,546		112,546		112,546			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		101,075	393,099	494,174		494,174		494,174			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,333,207	460,594	2,013,421	4,807,222		4,807,222	(146,727)	4,660,495			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(7,446)	30		9
10	Interest and Other Investment Income	(5,895)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,194)	2		13
14	Non-Care Related Interest	(48,415)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(150)	20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(4,367)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(119,387)	27		24
25	Fund Raising, Advertising and Promotional	(17,265)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,157)	20		28
29	Other-Attach Schedule	2,734			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (202,542)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	55,815		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 55,815		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (146,727)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SYCAMORE HEALTHCARE CENTRE

ID# 0045153

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 2734	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	2,734		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,194)	0	0	0	0	0	0	0	0	0	0	(1,194)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	138	0	0	0	0	0	0	0	0	138	4
5	Heat and Other Utilities	0	0	0	256	0	0	0	0	0	0	0	256	5
6	Maintenance	2,734	0	1,615	647	0	0	0	0	0	0	0	4,996	6
7	Other (specify):*	0	0	24	27	0	0	0	0	0	0	0	51	7
8	**TOTAL General Services**	1,540	0	1,777	930	0	0	0	0	0	0	0	4,247	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	10,442	5,344	0	0	0	0	0	0	0	0	15,786	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	126	5,177	41	1,500	0	0	0	0	0	0	6,844	19
20	Fees, Subscriptions & Promotions	(22,939)	0	781	0	0	0	0	0	0	0	0	(22,158)	20
21	Clerical & General Office Expenses	0	6,090	19,251	113	0	0	0	0	0	0	0	25,454	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	56	0	0	0	0	0	0	0	0	56	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	175	383	0	0	0	0	0	0	0	0	558	25
26	Insurance-Prop.Liab.Malpractice	0	0	255	134	0	0	0	0	0	0	0	389	26
27	Other (specify):*	(119,387)	839	3,453	0	0	0	0	0	0	0	0	(115,095)	27
28	**TOTAL General Administration**	(142,326)	17,672	34,700	288	1,500	0	0	0	0	0	0	(88,166)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(140,786)	17,672	36,477	1,218	1,500	0	0	0	0	0	0	(83,919)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(7,446)	0	204	783	135,072	0	0	0	0	0	0	128,613	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(54,310)	0	0	1,019	341,938	0	0	0	0	0	0	288,647	32
33	Real Estate Taxes	0	0	0	1,098	0	0	0	0	0	0	0	1,098	33
34	Rent-Facility & Grounds	0	0	0	0	(477,106)	0	0	0	0	0	0	(477,106)	34
35	Rent-Equipment & Vehicles	0	507	3,390	77	0	0	0	0	0	0	0	3,974	35
36	Other (specify):*	0	0	0	(8,034)	0	0	0	0	0	0	0	(8,034)	36
37	**TOTAL Ownership**	(61,756)	507	3,594	(5,057)	(96)	0	0	0	0	0	0	(62,808)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(202,542)	18,179	40,071	(3,839)	1,404	0	0	0	0	0	0	(146,727)	45

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
MORRIS ESFORMES	75			EMI ENTERPRISES	LINCOLNWOOD	CONSULTING
DANIEL WEISS	25			EKS MANAGEMENT	LINCOLNWOOD	BOOKKEEPING
		SEE ATTACHED SCHEDULE		IME REALTY CORP	LINCOLNWOOD	OFFICE RENT

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEE	$	EMI ENTERPRISES		$	$	1
2	V	17	OFFICERS SALARIES				10,442	10,442	2
3	V	19	ACCOUNTING FEES				126	126	3
4	V	21	TOTAL OFFICE				6,090	6,090	4
5	V	25	TRANSPPORTATION				175	175	5
6	V	26	INSURANCE						6
7	V	27	EMPLOYEE BENEFITS				839	839	7
8	V	35	AUTO LEASE				507	507	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 18,179	$ * 18,179	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	OUTSIDE CLERICAL	$	EKS MANAGEMENT		$	$	15
16	V								16
17	V	4	HOUSEKEEPING SALARIES				138	138	17
18	V	6	PAINTERS SALARIES				1,615	1,615	18
19	V	7	SCAVENGER				24	24	19
20	V	17	C F O SALARY				5,344	5,344	20
21	V	19	PROFESSIONAL FEES				5,177	5,177	21
22	V	20	WANT ADS/ BACK GR CKS				781	781	22
23	V	21	OFFICE EXPENSE				19,251	19,251	23
24	V	23	SEMINARS				56	56	24
25	V	25	TRANSPORTATION				383	383	25
26	V	26	INSURANCE				255	255	26
27	V	27	EMPLOYEE BENEFITS				3,453	3,453	27
28	V	30	DEPRECIATION				204	204	28
29	V	35	EQUIPMENT RENT				3,390	3,390	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 40,071	$ * 40,071	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	36	OFFICE RENT	$ 8,034			$	$ (8,034)	15
16	V								16
17	V	5	UTILITIES				256	256	17
18	V	6	REPAIRS / MAINTENANCE				647	647	18
19	V	7	ALARM SERVICE				27	27	19
20	V	19	PROFEESIONAL FEES				41	41	20
21	V	21	OFFICE EXPENSE				113	113	21
22	V	26	INSURANCE				134	134	22
23	V	30	DEPRECIATION				783	783	23
24	V	32	INTEREST				1,019	1,019	24
25	V	33	R/E TAX				1,098	1,098	25
26	V	35	STORAGE FEES				77	77	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 8,034			$ 4,195	$ * (3,839)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 477,106	QUINCY EXTENDED CARE LIMITED PARTNERSHIP		$	$ (477,106)	15
16	V	30	DEPRECIATION-SL				135,072	135,072	16
17	V	32	INTEREST				341,938	341,938	17
18	V	19	ACCOUNTING FEES				1,500	1,500	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 477,106			$ 478,510	$ * 1,404	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MORRIS ESFORMES	MEMBER	Administration	75.00	See Attached			Salary	$ 10,442	17-8	1
2	DANIEL WEISS	MEMBER	Administration	25.00	See Attached			mangmnt fee	40,000	17-8	2
3	AVRUM WEINFELD	CFO			See Attached			Salary	5,344	17-8	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 55,786		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EMI ENTERPRISES,INC
Street Address: 6865 N LINCOLN AVE
City / State / Zip Code: LICOLNWOOD, IL 60712
Phone Number: (847)674-1946
Fax Number: (847)674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICERS SALARY	PATIENT DAYS	881,303	14	$ 185,000	$ 185,000	49,745	$ 10,442	1
2	19	ACCOUNTING FEES	PATIENT DAYS	881,303	14	2,230		49,745	126	2
3	21	TOTAL OFFICE	PATIENT DAYS	881,303	14	107,899	87,197	49,745	6,090	3
4	25	TRANSPORTATION	PATIENT DAYS	881,303	14	3,109		49,745	175	4
5	26	INSURANCE	PATIENT DAYS	881,303	14				0	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	881,303	14	14,871		49,745	839	6
7	35	AUTO LEASE	PATIENT DAYS	881,303	14	8,991		49,745	507	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 322,100	$ 272,197		$ 18,179	25

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EKS MANAGEMENT, INC
Street Address: 6865 N. LINCON
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	4	HOUSEKEEPING SALARIES	PATIENT DAYS	881,303	14	$ 2,437	$ 2,437	49,745	$ 138	1
2	6	PAINTERS SALARY	PATIENT DAYS	881,303	14	28,615	28,615	49,745	1,615	2
3	7	SCAVENGER	PATIENT DAYS	881,303	14	429		49,745	24	3
4	17	C F O SALARY	PATIENT DAYS	881,303	14	94,671	94,671	49,745	5,344	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	881,303	14	91,723		49,745	5,177	5
6	20	WANT ADS / BCK GRND CKS	PATIENT DAYS	881,303	14	13,841		49,745	781	6
7	21	OFFICE EXPENSE	PATIENT DAYS	881,303	14	341,059	251,740	49,745	19,251	7
8	23	SEMINARS	PATIENT DAYS	881,303	14	984		49,745	56	8
9	25	TRANSPORTATION	PATIENT DAYS	881,303	14	6,783		49,745	383	9
10	26	INSURANCE	PATIENT DAYS	881,303	14	4,521		49,745	255	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	881,303	14	61,166		49,745	3,453	11
12	30	DEPRECIATION	PATIENT DAYS	881,303	14	3,617		49,745	204	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	881,303	14	60,061		49,745	3,390	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 709,907	$ 377,463		$ 40,071	25

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: IME REALTY CORP
Street Address: 6865 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	INCOME	312,263	15	$ 9,942	$	8,034	$ 256	1
2	6	REPAIRS / MAINTENANCE	INCOME	312,263	15	25,152		8,034	647	2
3	7	ALARM SERVICE	INCOME	312,263	15	1,056		8,034	27	3
4	19	PROFESSIONAL FEES	INCOME	312,263	15	1,575		8,034	41	4
5	21	OFFICE EXPENSE	INCOME	312,263	15	4,388		8,034	113	5
6	26	INSURANCE	INCOME	312,263	15	5,225		8,034	134	6
7	30	DEPRECIATION (SL)	INCOME	312,263	15	30,446		8,034	783	7
8	32	INTEREST	INCOME	312,263	15	39,619		8,034	1,019	8
9	33	REAL ESTATE TAX	INCOME	312,263	15	42,669		8,034	1,098	9
10	35	STORAGE FEES	INCOME	312,263	15	3,011		8,034	77	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 163,083	$		$ 4,195	25

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUICY EXTENDED CARE LTD. PTSHP
Street Address: 6865 N LINCOLN
City / State / Zip Code: LINCOLNWOOD,IL 60712
Phone Number: (847)674-5795
Fax Number: (847)674-6794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION-SL	DIRECT	1	1	$ 135,072	$	1	$ 135,072	1
2	32	INTEREST	DIRECT	1	1	341,938		1	341,938	2
3	19	ACCOUNTING FEES	DIRECT	1	1	1,500		1	1,500	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 478,510	$		$ 478,510	25

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1	RELATED PARTY ALLOCATION		X	MORTGAGE	$36,140.34	12/5/1	$ 5,000,000	$ 4,774,644	8/18/06	0.0725	$ 341,938	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8	RELATED PARTY ALLOCATION										1,019	8
9	TOTAL Facility Related				$36,140.34		$ 5,000,000	$ 4,774,644			$ 342,957	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11	Quincy Care Partnership	X			$9,003.00	01/01/02	1,157,443	986,735	12/01/16	0.0458	48,415	11
12												12
13												13
14	TOTAL Non-Facility Related				$9,003.00		$ 1,157,443	$ 986,735			$ 48,415	14
15	TOTALS (line 9+line14)						$ 6,157,443	$ 5,761,379			$ 391,372	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 34,270	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 34,605	2
3. Under or (over) accrual (line 2 minus line 1).		$ 335	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 34,605	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 34,940	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000	6,669	9
2001	33,328	10
2002	34,270	11
2003	34,605	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SYCAMORE HEALTHCARE CENTRE COUNTY ADAMS

FACILITY IDPH LICENSE NUMBER 0045153

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	23-4-1476-000-00	NURSING HOME	$ 34,605.12	$ 34,605.12
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 34,605.12	$ 34,605.12

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,691 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1997	$ 452,195	1
2					2
3	TOTALS			$ 452,195	3

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	RELATED PARTY		1997		$ 3,659,759	$ 93,840	39	$ 93,840	$	$ 738,990	4
5											5
6											6
7	RELATED PARTY					753		753			7
8											8
	Improvement Type**										
9	WALK IN COOLER			2001	18,153	660	27.5	660		2,234	9
10	SMOKE DAMPERS			2002	3,622	132	27.5	132		335	10
11	TILING			2002	8,511	309	27.5	309		786	11
12	FURNISHING - CARPETING			2002	10,276	1,380	5	2,055	675	6,165	12
13	FURNISHING - DRAPES			2002	20,425	2,746	5	4,085	1,339	12,255	13
14	FURNISHING - WALLPAPER			2002	6,185	831	5	1,237	406	3,711	14
15	FURNISHING - WINDOW & DOOR TREATMENTS			2003	21,042	3,998	5	4,208	210	6,417	15
16	DOORS			2004	4,169	82	27.5	82		82	16
17	WATER HEATER			2004	2,390	47	27.5	47		47	17
18	FIRE ALARM			2004	5,430	107	27.5	107		107	18
19	PARKING LOT			2004	14,398	120	15	480	360	480	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,774,360	$ 105,005		$ 107,995	$ 2,990	$ 771,609	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 217,583	$ 29,106	$ 21,758	$ (7,348)		$ 58,877	71
72	Current Year Purchases	6,859	3,685	343	(3,342)		343	72
73	Fully Depreciated Assets							73
74	RELATED PARTIES	410,000	41,466	41,466			123,232	74
75	TOTALS	$ 634,442	$ 74,257	$ 63,567	$ (10,690)		$ 182,452	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		USED VAN	2001	$ 3,000	$ 346	$ 600	$ 254	5 YRS	$ 2,400	76
77										77
78										78
79										79
80	TOTALS			$ 3,000	$ 346	$ 600	$ 254		$ 2,400	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,863,997	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 179,608	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 172,162	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (7,446)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 956,461	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

PLEASE ENTER ONLY DATES IN CELLS W16 AND W17

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning / /
Ending / /

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 9,066 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17		2003 JEEP GR CHEROKI	$ 522.00	$ 5,925	17
18		2004 FORD WAGON	785.00	9,420	18
19					19
20					20
21	TOTAL		$ #######	$ 15,345	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-8	hrs	$		$ 37,183	$		$ 37,183	1
2	Licensed Speech and Language Development Therapist	39-8	hrs			30,973			30,973	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care	39-8	visits			193,401			193,401	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescrpts				76,803		76,803	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): supplies, lab,	39-8				18,996	24,272		43,268	13
14	TOTAL			$		$ 280,553	$ 101,075		$ 381,628	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 19,820	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 50,000)	704,766		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	75,263		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Real Estate Escrow Deposit	41,127		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 840,976	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	56,673		15
16	Equipment, at Historical Cost	314,296		16
17	Accumulated Depreciation (book methods)	(259,292)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 111,677	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 952,653	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 151,908	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	75,270		30
31	Accrued Taxes Payable (excluding real estate taxes)	35,350		31
32	Accrued Real Estate Taxes(Sch.IX-B)	34,605		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 297,133	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DUE TO QUINCY EXT CARE PTNR	986,735		43
44	DUE TO MEMBERS	568,189		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,554,924	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,852,057	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (899,404)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 952,653	$	48

*(See instructions.)

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (909,227)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (909,227)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	199,823	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(190,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 9,823	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (899,404)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,803,713	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,803,713	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	197,437	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 197,437	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,895	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,895	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,007,045	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	954,350	31
32	Health Care	1,826,207	32
33	General Administration	896,036	33
	B. Capital Expense		
34	Ownership	636,455	34
	C. Ancillary Expense		
35	Special Cost Centers	381,628	35
36	Provider Participation Fee	112,546	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,807,222	40
41	**Income before Income Taxes (line 30 minus line 40)****	199,823	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 199,823	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,092	2,246	$ 45,815	$ 20.40	1
2	Assistant Director of Nursing	2,080	2,246	38,145	16.98	2
3	Registered Nurses	3,748	4,011	64,670	16.12	3
4	Licensed Practical Nurses	38,587	40,669	557,426	13.71	4
5	Nurse Aides & Orderlies	79,237	86,289	694,002	8.04	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	13,074	13,821	149,180	10.79	8
9	Activity Director					9
10	Activity Assistants	7,724	8,284	70,558	8.52	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,097	2,339	42,634	18.23	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,100	21,092	152,492	7.23	15
16	Dishwashers					16
17	Maintenance Workers	5,873	6,339	82,497	13.01	17
18	Housekeepers	17,214	17,954	125,967	7.02	18
19	Laundry	11,160	11,576	96,827	8.36	19
20	Administrator	2,080	2,123	70,000	32.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,941	5,389	60,481	11.22	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,751	6,221	55,450	8.91	31
32	Other Health C: nrsg adm,	1,521	1,845	27,063	14.67	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	217,279	232,444	$ 2,333,207 *	$ 10.04	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY	$ 8,803	1-3	35
36	Medical Director	MONTHLY	12,000	9-3	36
37	Medical Records Consultant	MONTHLY	2,250	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	MONTHLY	3,284	10-3	39
40	Physical Therapy Consultant	MONTHLY	1,861	10a-3	40
41	Occupational Therapy Consultant	MONTHLY	247	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	MONTHLY	87	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant	MONTHLY	8,099	12-3	45
46	Other(specify) psychiatric conslt	MONTHLY	9,750	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 46,381		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Nurse Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
VIOLA PENNINGTON	ADMIN	0	$ 70,000
	ASST ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 70,000

B. Administrative - Other

Description	Amount
DANIEL WEISS	$ 40,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 40,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SEE ATTACHED SCHEDULE		35,513
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 35,513

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 82,099
Unemployment Compensation Insurance	55,544
FICA Taxes	174,384
Employee Health Insurance	57,386
Employee Meals	1,373
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	14,659
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 385,445

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,050
Advertising: Employee Recruitment	5,902
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	18,422
TRUST/FRANCHISE/CONTRIB/ETC	4,517
LICENSES & PERMITS	809
DUES & SUBSCRIPTIONS	6,464
MGMT CO ALLOCATION	781
TRUST/FRANCHISE/CONTRIB/ETC	(4,517)
Less: Public Relations Expense	(0)
Non-allowable advertising	(17,265)
Yellow page advertising	(1,157)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,006

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	2,707
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,707

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINTING/DECORATIN	2001	$ 947	3 YRS	$ 157	$ 316	$ 316	$ 158	$	$	$	$	$
2	PAINTING/DECORATIN	2002	7,728	3 YRS		1,288	2,576	2,576	1,288				
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 8,675		$ 157	$ 1,604	$ 2,892	$ 2,734	$ 1,288	$	$	$	$

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $6,223**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,030** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **112,546**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **1,373** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees